FACTORS ASSOCIATED WITH UTILIZATION AND QUALITY STATUS OF POST-ABORTION CARE (PAC) SERVICES, ATTAT CATHOLIC HOSPITAL, GURAGEA ZONE, ETHIOPIA, 2019

A RESEARCH THESIS TO BE SUBMITTED TO JIMMA UNIVERSITY, COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES, RESEARCH AND POST GRADUATE COORDINATING OFFICE, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN INTEGRATED EMERGENCY OBSTETRICS AND GYNECOLOGY AND GENERAL SURGERY

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JIMMA UNIVERSITY

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ABSTRACT

BACKGROUND: Unsafe abortion is one of the leading causes of maternal mortality and morbidity worldwide accounting for 13% of maternal deaths globally. Ethiopia is one of the developing countries with the highest maternal mortality ratio (412 per 100,000 live births) in the world. Unsafe abortion was estimated to account for 9% to 12% of all maternal deaths in Ethiopia. In Ethiopia, utilization of post-abortion care service is minimal and it seems that the expanding services are underutilized.

OBJECTIVE: To assess factors influencing utilization and quality status of post-abortion care in Attat catholic hospital, 2019

METHODS- This study was conducted at Attat Catholic Hospital (ACH) which is found 175 km southwest of Addis Ababa. A facility based cross-sectional study design with both quantitative and qualitative methods were conducted. All reproductive age women who were visited gynecology out-patient and inpatient department of Attat general hospital from January1, 2019 to July 30 2019 153 Patients will be interviewed, direct service observation, and 15 providers were self-administered questionnaire and in-depth interview, This was done through a quota sampling technique which is a recommended method to study abortion in a facility setting. Data were entered into Epi Info and analyzed by using SPSS version 21 software for windows. Bivariate and multivariate logistic regression analyses were done.

RESULT; - Patient-provider interaction was generally satisfactory from the patient's perspective. The majority of the respondents (125(81.7%) said that they were treated with politeness and respect. More than half of the client 130(85 percent have not received post abortion family planning. Overall, 77.1% of the patients were satisfied with the services. Those who said has language abused and have no rest room after procedure, waiting time was long were less satisfied than others**.**

CONCULUTION; **-** The interaction of patients and service providers was satisfactory. However, from a clinical service delivery standpoint, important medical information on danger signs, follow-up needs of post abortion family planning and care associated keep privacy during counseling were neglected by most of the health professionals. Most of the clients were satisfied with the service provision. Long waiting time was associated with less level of client satisfaction and not abused with language and had rest room after the procedure of PAC service were more satisfied than others.

KEY WORDS;- Quality, Post abortion care, Abortion, Health facility

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LIST OF ABBREVIATIONS

CHWs Community Health Workers

GBV Gender Based Violence

D&C Dilate & Curettage

EmOC Obstetric Emergencies

FGDs Focus Group Discussion

HIV Human Immunodeficiency Virus

ICDP International Conference on Population and Development

IPAS International Pregnancy Advisory Services

MDGs Millennium Development Goals

MMR Maternal Mortality Rate

MoH Ministry of Health

MVA Manual Vacuum Aspiration

NGO Non-Governmental Organization

PAC Post-Abortion Care

PCC Postabortion Care Consortium

PHSDP Primary Health Services Development Programme

PPH Postpartum Haemorrhage

SDGs Sustainable Development Goals

SPSS Statistical Package for the Social Sciences

STI Sexually Transmitted Infection

TDHS Tanzania Demographic and Health Survey

UNFPA United Nations Population Fund

USAID United States Agency for International Development

WHO World Health Organization

CHAPTER ONE: INTRODUCTION

1.1 Background

Unsafe abortion is one of the leading causes of maternal mortality and morbidity worldwide accounting for 13% of maternal deaths globally [1,4,5]. In sub-Saharan Africa, up to 50 percent of gynecological beds are occupied by patients with abortion complications [6]. In the vast majority of African countries, abortion remains both unauthorized and unsafe. Safe procedures are accessible only to wealthier and more educated women, leaving the poor, and often marginalized, women to suffer disproportionately [3]. What is most disconcerting is the fact that unsafe abortion in some countries affects young women and teenagers. Approximately, 40% of all unsafe abortions are performed on young women aged 15 to 24 years [7,8].

The utilization of PAC services Ethiopia is one of the developing countries with contraceptive prevalence of less than 15% [4] and highest maternal mortality rate estimated to be 412 per 100,000 live births. Unsafe abortion was estimated to account for 9% to 12% of all maternal deaths in Ethiopia(1,4. The main contributing factors for this high death toll include unsafe abortion among others. Several studies in Ethiopia indicate that unsafe abortion may account for up to 25 to 35 percent of the maternal deaths [9-11].

Safe abortion services have been unavailable throughout much of Ethiopia's modern history. The 1957 penal code allowed abortions only to save the life or health of the woman. Combined with low rates of contraceptive supplies, use, and high rates of sexual violence, the restrictive law compelled many Ethiopian women to seek out the services of unskilled, back-street abortion providers [12,13].

To respond to the problem in an efficient way, Ethiopia had developed a comprehensive PAC approach in 1991. The approach included emergency treatment of incomplete abortion and its complications, family planning counseling and services, and linking the emergency treatment along with other reproductive health services. Recently, the post-abortion care consortium developed an expanded and updated model which includes two more elements, i.e., providing appropriate counseling based on individual needs and community-provider partnership in prevention of unsafe abortion andcare [14].

Ethiopian Parliament passed one of Africa's most progressive abortion laws. The new penal code added indications for rape, incest, fetal abnormality, and a woman's physical or mental disabilities. The Parliament also approved abortion for minors physically or psychologically unable to care for a

child. No consent from spouse, partner or parent is required to obtain a legal abortion and no requirements exist for legal reporting or documenting rape or incest as prerequisite for obtaining a legal abortion [12,13]. Women can have an early pregnancy loss from either a miscarriage or self-induced abortion. Both can be life threatening from hemorrhage, infection, shock, and blood clotting problems.

One surprising finding in most studies is the lack of quality post abortion care and women are treated without any pain relief and with risky methods such as sharp curettes. Even more disconcerting was that after a pregnancy loss, women were not given family planning information or supplies to space their next pregnancy [9]. Restrictive national laws, lack of access to safe abortion and lack of quality post-abortion car have led to the premature death of millions of mothers [10,11].

So far studies done in Ethiopia have addressed mostly the magnitude, cause, setting and distribution of abortion. In addition, while several studies have examined reproductive health service utilization in both developed and developing countries there is only scant information available about quality of post abortion care in health facilities from Ethiopia except a few facility based studies on quality of PAC in the country. This study will be believed to fill such an information gap and enable to identify areas of service improvement. Therefore the objective of this study was assess the post abortion care utilization and quality status in attat catholic hospital of Guraghe zone, Ethiopia.

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1.2 Statement of the Problem

K2Ending the silent pandemic of abortion is an urgent public-health and human-rights imperative. As with other more visible global-health issues, this scourge threatens women throughout the developing world. Worldwide estimates for 1995 indicated that about 26 million legal and 20 million illegal abortions took place every year. Almost all unsafe abortions (97%) are in developing countries, and over half (55%) are in Asia (mostly in south-central Asia). **[1,4,7]**

Morbidity is a much more common consequence of abortion than mortality, but is determined by the same risk factors. Complications include hemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs. High proportions of women (20–50%) who have unsafe abortions are hospitalized for complications. National studies show that the rate of hospitalization varies from a low of three per 1000 women per year (in Bangladesh, where menstrual regulation is legally permitted) to a high of 15 in Egypt and Uganda. An estimated 68 000 women die as a result, and millions more have complications, many permanent. The availability of modern contraception can reduce but never eliminate the need for abortion. Direct costs of treating abortion complications burden impoverished health care systems, and indirect costs also drain struggling economies. [5, 9, 11]

Access to PAC is also mediated by women's awareness of the law. Knowledge is often poor, even in countries with longstanding liberal laws. Misperceptions about the specifics of the law are not uncommon, thus making women vulnerable to poor care, financial exploitation, and prosecution.Even where legal abortion is widely available on request, misperceptions about the legality of minors having sexual intercourse delay some adolescents from seeking care. In many cultures, perceptions of legality are affected by the stigma attached to premarital or extramarital sexual activity. In several south Asian countries, such pregnancies are commonly referred to as illegal or illegitimate, as are the abortions induced in these circumstances. Misperceptions about legal requirements, such as the need for spousal authorization and provider attitudes, could create barriers that do not exist in law.[6,13]

Treatment of abortion complications burdens public health systems in the developing world. Conversely, ensuring women's access to safe PAC lowers medical costs for health systems. In some low-income and middle-income countries, upto 50% of hospital budgets for obstetrics and gynecology are spent treating complications of abortion.. Post-abortion care

offered in tertiary hospitals by physician providers was estimated to cost health systems ten times more than elective abortion services offered by mid-level practitioners in primary care. [10, 15]

Unsafe abortion is a persistent, preventable pandemic. WHO defines unsafe abortion as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both.Unsafe abortion mainly endangers women in developing countries where abortion is highly restricted by law and countries where, although legally permitted, safe abortion is not easily accessible. In these settings, women faced with an unintended pregnancy often self-induce abortions or obtain clandestine abortions from medical practitioners,paramedical workers, or traditional healers.By contrast, legal abortion in industrialized nations has emerged as one of the safest procedures in contemporary medical practice, with minimum morbidity and a negligible risk of death. As with AIDS, the disparity between the health of women in developed and developing countries is stark. Unsafe abortion remains one of the most neglected sexual and reproductive health problems in the world today. This article will describe the scope of the problem of unsafe abortion, estimate its mortality and morbidity, document the relation between laws and women's health, estimate costs, and describe prevention strategies. [1, 10]

CHAPTER TWO. LITERATURE REVIEW

2.1 literature review

This chapter provides a review of the literature on PAC services and factors associated with its utilization. It is divided into four main parts. The first part focuses on the relationship between abortion, maternal mortality and PAC; and the origin of and the rationale for PAC services. The second part provides information on empirical studies on factors associated with the utilization of PAC services. The third part focuses on theories on health-seeking behaviour and the description of the framework that guided the study

. 2.1,1 Abortion and Maternal Mortality

In 2011, an estimated 21.6 million unsafe abortions were carried out worldwide with a large proportion occurring in developing countries. In Africa, the highest rates were observed in East Africa (38/1,000), Central Africa (36/1,000), West Africa (28/1,000) and North Africa (18/1,000). In developed countries, the rate was estimated to be (1/1,000) (19,20). .

The complications associated with induced abortion may be fatal or non-fatal depending on the method used to induce abortion, the skills of the abortion provider, the facilities, the readiness to seek care and the availability and quality of PAC services (33).

Not all induced abortion complications are treated. Some women who had had an induced abortion may experience complications but do not seek care from health facilities due to fear of being arrested by the police, lack of appropriate information about PAC services, or preference to seek care from untrained providers (24). .

Women who experience unsafe abortion complication may die. About 97 percent of maternal mortality associated with abortion complications occur in developing counties compared to 3 percent in countries where abortion is legal (33). Mortality due to unsafe abortion are mainly caused by severe bleeding or infection caused by unsafe procedure or due to organ damage (16,17)**.**

Deaths due to abortion complications are the easiest to prevent ,These deaths can be prevented if PAC services are sought promptly following abortion complications and the care provided is of high quality (24.). Factors which may increase the risk of maternal mortality among women

experiencing abortion complications include delays for recognizing the need for care, lack of equipment at the facility, negative attitude towards abortion, lack of transport and delayed care after reaching the facility (24).

Therefore, prompt seeking of care following abortion complication and receiving quality PAC services upon reaching the facility may help to minimize the risks to maternal mortality (24)

2.1.2 Quality PAC Services

Women with abortion-related complications, whether due to spontaneous or induced abortion have the right to immediate high quality care. They have the right to emergency treatment regardless of their age, political beliefs, ethnic background, marital status or their family size (23). The provision of quality PAC was emphasized in the ICPD-POA which states clearly that: ―in all cases women shall have access to quality services for management of complications arising from abortion‖. It was agreed at the ICPD that PAC counselling, education and family planning services should be offered promptly in order to avoid repeated abortions 41).

In 1995, Jhpiego1 developed guidelines which describe the elements of a quality post-abortion programme which recommends that:

Services are provided safely and efficiently

Women are treated in a non-judgmental manner

PAC family planning services are widely available

Well-established links to other health care services are ensured

Another aspect of quality PAC services is that they are woman-centred. Woman-centred PAC services means safe and timely services tailored to a woman‘s medical and personal needs, respectful and confidential care and the right to information, privacy and informed choice. Woman-centred PAC would aim to meet each woman‘s needs at the time of treatment to ensure that women receive high-quality PAC services that cater for their needs. Healthcare providers will need to take into consideration factors that influence each woman‘s need for and access to care, including her personal circumstances and her living conditions, in the provision of woman-centred PAC (36).

2.1.3 Empirical Studies on Factors Influencing Utilization of PAC Services

PAC services are considered a potential strategy for addressing morbidity and mortality associated with unsafe abortion (24). Women experiencing abortion-related complications may benefit from PAC services upon receipt of the right care in a timely manner (23,24). Factors that may facilitate or hinder the utilization of PAC services emanate from the individual, community and healthcare system factors as presented below.

2.2.Individual socio demographic Factors

2.2.1 Age

A lot of literature indicate that younger women are more likely to experience induced abortion (28).

Regional variations in the age pattern of induced abortion still exist. Over 25 percent of all unsafe abortions in Africa occur among adolescents (15-19 years) while 42 percent and 33 percent of unsafe abortions in Asia and Latin America respectively occur among women aged 30-44 (30). Unmarried women particularly adolescents have little or no information about counselling, reproductive health issues and contraceptive services especially in countries where abortion is restricted (19,20,21).

Generally, adolescents are more likely to be seriously affected by complications than older women (16).

They are more likely to delay or not seek care for abortion-related complications. The delays or inability to seek care may be caused by fear of health-care providers‘ attitude, lack of transport, poor knowledge of where to obtain PAC services, lack of money to pay for PAC services and stigmatization (28,29,30).

2.2.2 Education

Formal education attainment empowers women and increases their autonomy which influence their fertility decisions (25,26).

Women with formal education are more likely to be aware of the availability of health services. Their education may enhance their socio-economic status which may enable them to seek proper medical care (27). Education may facilitate contraceptive use by increasing a woman‘s economic

power and ability to purchase contraceptives. It may further determine their access to safer methods of abortion and the type of PAC services to be sought in case of complications (28).

Desire to attain education and career development may lead to postponement of marriage among younger women in places where there are great opportunities for education. Therefore, abortion may be frequent in such settings in case of unintended pregnancy.

Education may have a positive impact on the utilization of PAC services. The attitude of the community on PAC services is more likely to be positive where its members are educated. .

2.2.3 Marital Status .

Young and unmarried women have greater chances of experiencing difficulties in seeking PAC services in case of abortion-related complications in settings where out-of-wedlock pregnancy is morally sanctioned. A study in Indonesia found that providers showed compassion to married women requesting an abortion, especially for child spacing or due to contraceptive failure (37). Another study in Indonesia found that young unmarried women were denied menstrual regulation services because of providers‘ punitive attitude to their marital status, despite abortion being legally permitted. They were sometimes charged more money (four times) than married women in private hospitals (29).

Being married in a stable relationship does not always guarantee the husband‘s support for abortion and PAC services. Some studies have found that married women unable to access PAC services due to their husbands‘ objection (38). .

2.2.4 Religion

Religion is among the powerful instruments that may influence an individual‘s cognition, social attitudes and behaviour (39).. However, in most cases abortion is frequently condemned by religious ideologies and teaching Believers who belong to highly intolerant or proscriptive faiths tend to view abortion as murder, and hold a strong belief that those who perform abortions and those who obtain abortions are sinners. Some religious beliefs perceive it as a taboo for a woman to expose her body to a stranger, particularly to a male attendant. experiencing abortion-related complications but also the providers of PAC services. The clerics considered the PAC providers as murderous, and they always hound them. The study further noted that religion and females‘ restricted mobility were among the barriers to the utilization of PAC services (38).

Islamic teachings largely emphasize women‘s restricted freedom. This has been associated with poor mortality outcomes among Islamic societies . Furthermore, Roman Catholics discourages the use of modern contraceptives (38). These religious teachings may also influence the perceptions and the use of PAC services among the believers in case of abortion complications; given the powerful ability of religion to shape and change people‘s attitudes and behaviour (39).

2.2.5 Socio-Economic Status

Socio-economic status which is largely determined by the indicators of income, education and employment is related to health in various ways, including the utilization of health services (27). Research evidence suggest a strong correlation between socio-economic status and the use of health care services). Modern health services are more likely to be utilized by the affluent members of the community (27

Women who are economically stable are more likely to have better access to less risky methods of abortion. On the other hand, poor and uneducated women who live in rural areas are likely to seek abortion from traditional practitioners. They are likely to face greater risks of experiencing complications and higher chances of not obtaining PAC services (19,20).

The probability of poor women suffering from complications from unsafe abortion is 42-67 percent while that of better-off women is much lower, 28-38 percent (19,.20). Poor women are more likely to use traditional methods to induce abortion because of poor knowledge of safe procedures or the inability to pay for abortion services . They may have poor access to PAC services due to inadequate health facilities offering PAC services (19,20).

2.2.6 Awareness of PAC Services

Induced abortion carries with it some risks regardless of the type of the abortion procedure. The risks of safe abortion depend on the skill of the provider, the gestational age of the foetus and the type of health facility. The risk of unsafe abortion depends on, among other factors, the method used to terminate the pregnancy and the readiness of a woman to seek PAC services (28). Abortion-related complications may be severe but women may delay or not seek PAC services due to their poor knowledge of the availability of PAC services or because of stigma (41,42).

2.2.7 Decision Making and Resource Control at Household Level

. Some research findings indicate that the objection of the husband, in-laws and other family members is among the factors constraining the utilization of PAC services (38,41). This implies that a woman may experience an illness however, the decision to seek help may be made by her husband or other family members. The decision to seek care may further be influenced by those who control the resources at household level. Intra-household resource allocation may have a gender bias, hence affecting women‘s access to health services (16,17).

3 Health System Factors

3.1 Quality of Services

Peoples‘ perceptions on the quality of healthcare services may determine whether they will continue seeking and using the services (23).

The literature has highlighted various determinants of the users‘ perceptions on the quality of health services. The determinants include short waiting time and respect for privacy (19) provider behaviour , competency of the healthcare providers, and the availability of drugs (19,20).

Studies on the quality of PAC services have documented both good and poor aspects. Some of the good qualities of PAC services are: very good MVA practices and providers competent in providing PAC services (43,44). On the other hand, some of the documented poor quality of PAC services are long waiting time, inadequate or minimal practice of MVA, inadequate family planning services, lack of privacy, lack of on-the-job training, providers giving inappropriate information to the users of PAC services and unnecessary administration of antibiotics (43.44,42). Women in need of PAC services are more likely to be discouraged from seeking care when the quality of the services are poor and vice versa.

3.2 Healthcare Providers’ Attitudes

The attitudes of the healthcare providers have been identified as among the factors that may hinder or facilitate utilization of health care services. Some providers have a negative attitude or are uncomfortable dealing with abortion cases. Therefore, their attitude may lead to women receiving low quality abortion-related services (29.30). Furthermore, some providers may refuse

to provide abortion services to women for reasons of conscience or may even fail to refer them to other facilities (19,20). Adolescents may be affected disproportionally by the attitude of providers on abortion . They may not seek care for fear of being judged negatively for having an induced abortion . Stigma attached to abortion may have a negative effect on providers‘ willingness to provide abortion and PAC services. In Ghana for example, stigma prohibits healthcare providers from offering PAC services although they are willing to do so. In both the community and professional sphere, obstetricians and gynaecologists are marginalized. In some instances, their properties are labeled abortion properties. For example, when a PAC service provider has a new car or house, it is labelled _abortion car‘ or _abortion house‘. The labelling discourages them from performing an abortion as well as obtaining training for abortion-related services (45).

Judgmental attitudes of the provider affect the seeking and utilization of PAC services. Melkamu and colleagues documented that a significant proportion of women in Ethiopia did not seek PAC services due to mistreatment by healthcare providers (25).

3.3 Healthcare Providers' Competencies

The competencies of healthcare providers and the availability of PAC services may influence the utilization of PAC services. In Bangladesh, a report on factors associated with access to and quality of menstrual regulation (MR) and PAC services found that inadequate equipment and training of the PAC service providers were among the barriers to the utilization of PAC services (41).

A study in Ethiopia found that some PAC patients reported to have 47 visited at least one health facility before obtaining treatment because of shortage of healthcare provides for PAC services (31).

The stigma associated with performing an abortion may hinder healthcare providers from providing abortion and PAC services effectively although they may be competent and well trained to offer PAC services (44).

3.4 Healthcare Providers' Sex

The healthcare provider‘s sex has been documented to have an influence on the use of health care services. Research findings on the influence of providers‘ sex on the utilization of

healthcare services are diverse. However, most of them indicate that women providers are more likely to devote more time to clients and adopt client-centred communication (45).

Women may be prohibited from visiting a health facility in case of illness in settings where women are restricted to expose their bodies to a male attendant (42).

3.5 Distance to the Nearest Health Facility

Physical accessibility and transportation may have influence the utilization of healthcare services. Long distance to a healthcare facility is likely to influence utilization negatively. Transport costs and proximity to the nearest hospital or health center are found to be among the strong predictors of healthcare utilization (32). .

.2.2. Significance of the Study

Abortion related maternal morbidity and mortality in developing countries especially in Sub-Saharan country are very high. Ethiopia as a member of sub Saharan African country contributes a huge number in maternal morbidity and mortality; to reduce this and to achieve the millennium development goal the country works hard in a multi directional way this includes the accessibility of compressive obstetric care in health institutions. The findings of this study will be expected to provide the hospital, policy makers and Nongovernmental Organization (NGOs) with relevant information about the factors associated with utilization and quality of abortion for future planning of appropriate strategies and also be used by program implementers as an input towards improving quality of obstetrics gynecology care and with their ultimate goal of reducing maternal mortality and as a base line for scientific community study.

2.3. Conceptual Frame Work of the Study

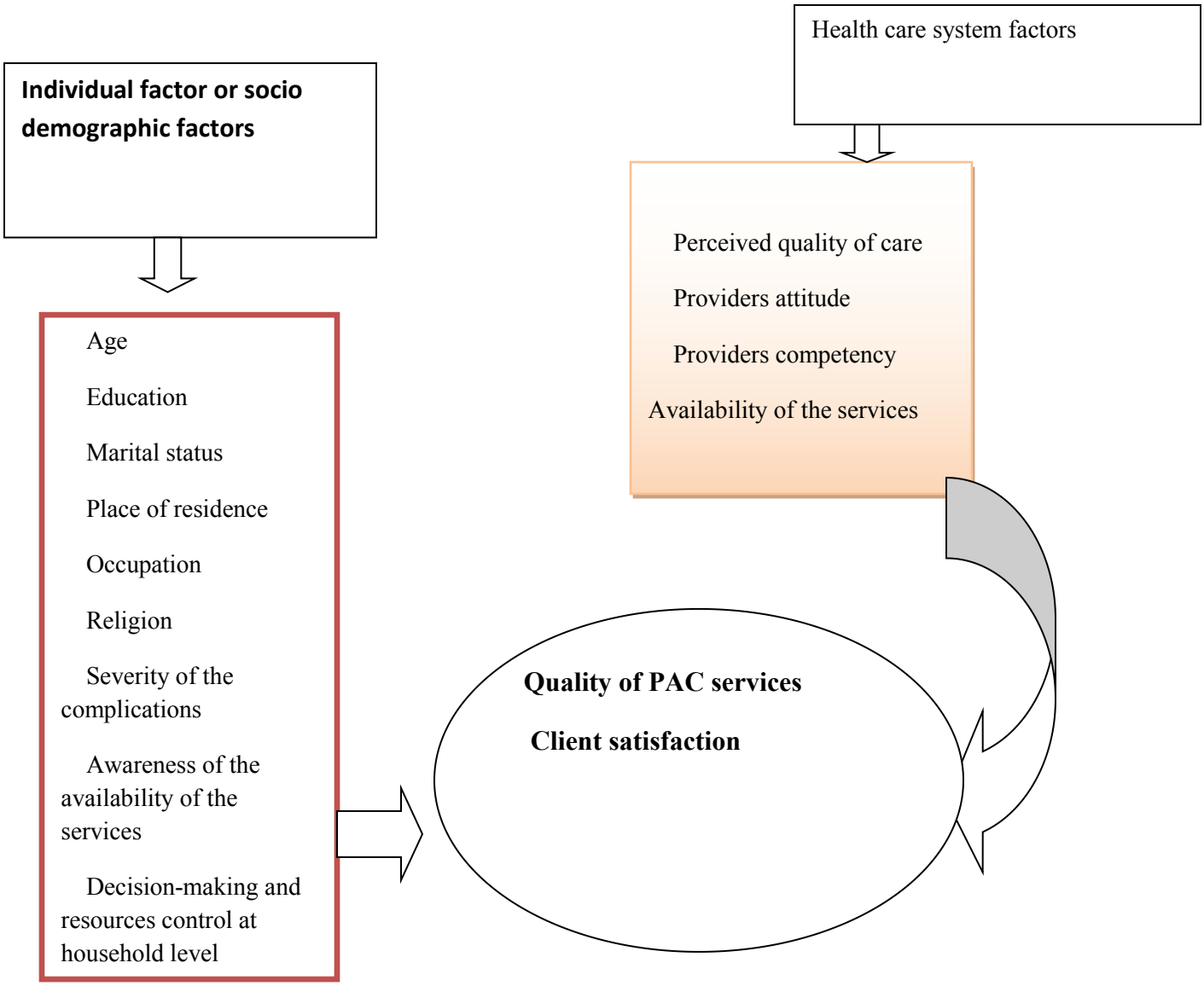

Figure 1: Conceptual framework explaining the relationship between the independent and the outcome variable

CHAPTER THREE: Objectives of the Study

3.1. General objective

To determine factors influencing utilization and quality of post abortion care in Attat primary hospital from January, 2019 to July ,2019

3.2. Specific objective

1, To determine factors influencing utilization of PAC service in Attat Hospital. From January, 2019 to July ,2019

2, To identify the users of PAC services and factors that facilitate and those that hinder the use of PAC services 2019 to July, 2019

3,To establish the perceptions of the providers and users of PAC services on the quality of PAC 2019 to July ,2019

CHAPTER FOUR:METHODOLOGY

4.1. Study Area and Period

This study will be conducted at Attat Catholic Hospital (ACH) which is found 175 km southwest of Addis Ababa and is 410 km far from the regional capital, Awassa. The Hospital was established in 1961 E.C with a mission of religious expansion. It is located about 2100 meters above sea level. Its catchment's population is 800,000 mainly centered for Cheha Woreda of Gurage Zone. This study covers six months review from January1,2019 to July 31,2019

4.2. Study Design

A facility based cross-sectional study involving both quantitative and qualitative methods was conducted. The study has measured the following aspects of utilization and quality of PAC; client satisfaction, providers technical competence, availability of equipment and supplies.

4.3 Source Population

All reproductive age women who were visited gynecology out-patient and inpatient department of Attat general hospital from January 1, 2019 to July ,30 2019

4.4. Study Population

Women who sought PAC services and health care providers directly were involved in PAC services in Attat primary hospital that provide PAC service during the study period. .

4.5. Eligibility Criteria

4.5.1 Inclusion Criteria

Users of PAC services women who were experienced abortion-related complications and sought PAC services from Attat primary hospital during the study period. They formed the unit of analysis for the study. They were provided information on factors that facilitated the utilization of PAC services. They also provided information on and the perceived quality of PAC services they were received at the study facility.

Providers of PAC services: Providers of PAC services the healthcare providers were involved in delivering PAC services in the study facilities. The study was intended to interview all the providers who were involved in the delivery of PAC services in the study facility how ever, only the provider available during the study period was interviewed. They provided information on perceived quality of PAC services and perceptions on abortion and PAC services. Healthcare providers perceptions on abortion and PAC services may influence the health-seeking behavior

4.5.2. Exclusion Criteria

, those patients who have hearing problem, mentally disabled, patients who declined to participate, the severely ill, patients who left against medical advice or had a gestational age greater than 28 weeks were excluded from the study.

4.6. Sample Size Determination

The sample size is calculated using single population proportion formula with estimated proportion of post abortion care utilization among women aged 15 - 49 years put at 10% [13]. Assuming a marginal error of 5% and a 10% non-respondent rate, the estimated sample size is 153

4.7 Sampling technique

All post abortion patients consecutively discharged from Attat primary hospital were included in the study until the required number of cases reached . This was done through a quota sampling technique which is are commended method to study abortion in a facility setting[2].

4.8. Operational definitions.

1. **Post abortion patients**: are any patient presenting with sign and symptom of abortion and declared by the provider in charge as having an abortion regardless of the cause and type.

2. Providers: refers to health professionals involved in history taking, physical examination, treatment and counseling of post abortion cases.

3. Quality: "Quality of PAC" assessed based on client satisfaction, providers technical competency and set up or facility assessment.

4. Client satisfaction: overall client's perception toward the PAC services she received.

5. Patient provider interaction: "Provider who possesses good listening skills understanding and cares for the woman in "respectful" way and in a private environment.

6. Technical competence: refers to qualification, training background, skills and experience of providers.

7. Information received: when a post abortion patient received information on family planning, danger signs and need for follow up 'as much as the patient wanted'.

4.9. Measurements

4.9.1. Instruments

The choice of a data collection tool is determined by the purpose of the research, the resources available and researcher's skills. This study was employed a range of data collection instruments. Exit-interviews, in-depth interview guide, and observation checklist was the main data collection instruments were used in the study. The study instrument can be found in Appendix .

4.9.2 Exit-Interviews

A semi-structured questionnaire was administered to the participants when they were about to leave the facility after receiving PAC services. This instrument was collected information on their basic characteristics, factors that were facilitated their seeking of PAC services and their perceptions on the quality of services. Only patients who agreed to participate were interviewed. . The questionnaire was consisted of three major parts. The first part was collected information on the basic characteristics of the participants. The second parts were collected information on factors that enabled them to seek PAC services. The third part was gathered information on their perceptions on the quality of PAC services. Aspects of the quality of PAC services covered sex of the provider, counseling, privacy, family planning, , facility location and set-up, waiting time and the perceptions of the care provider .

4.9.3 In-Depth Interviews

In-depth interview is a qualitative research technique which will be collected information from a small number of respondents. It explores their views on a certain program idea or situation. In-depth interviews are mostly used when detailed information is needed on people‘s thoughts, understanding and behavior or when exploring new issues in depth (42

In this study, in-depth interviews were carried out with the users who have complication of abortion and health care providers of PAC services.

4.9.4. pre test

Before the actual data collection, the questionnaire was tested on 5% (8) patients of the total study population out of study site at quanta primary hospital

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4.10 Variables of the Study

4.10.1 Dependent Variable

- Client satisfaction on PAC services

4.10.2 Independent Variables

- Socio demographic status
- Waiting time to get hospitals’ outpatient services
- Client provider relationship

- Payment status
- Access and availability of materials and drugs
- Range of services of PAC

.Providers perception towards Post abortion patients

4.11. Quality Assurance

All data collection instruments will be pretested at one of the PAC service delivery sites. As part of the pre-test, PAC providers were interviewed, inventory will be made for the supplies and equipment. Five percent of sample size was employed for pretest and revisions to the data collection instrument subsequently were made to avoid bias the data were collected by nurses who have ever been trained on PAC.

4.12 Method of Data Analysis

The collected data was checked for its completeness and entered to SPSS- version 21 or analysis after edition. Frequency distributions and mean with standard Deviation were used for description of independent variables and the association between independent and dependent variables were tested using chi square. To identify factors of quality of post abortion care, bivariate and multivariate logistic regression was used. A 95 %confidence interval and 5% level of precision was utilized to declare presence of association between dependent and independent variables in final model. Finally, the data was presented by using table's charts and words

4.13. Ethical Consideration

Ethical clearance was obtained from Jimma University college of health sciences, Research and community service office was conducted the study. Further permission was obtained from Regional Health Bureau of SNNP, Guragea zone, Medical Director of Attat Hospital and the department head of the obstetric ward. Informed verbal consent also obtained from the clients before commencing the study and confidentiality was assured

4.14. Dissemination Plan of the Study Findings

Findings will be presented during Master's thesis defense. The results of study will be submitted to the department and will be disseminated to the study site and other concerned bodies. Also there will be an attempt to publish the result in a standard journal

CHAPTER FIVE-: RESULTS

5.1 Socio-demographic characteristics

One hundred fifty three women were identified and interviewed from study health facilities. All women are participated in the study making the response rate 95%. The age of post-abortion clients ranged from 15 to 49 years with a mean age of 27.2 years (SD ± 13.3). A total of 44(28.8%) participants were in the age group between 20 to 24 years. Eighty seven (56.2%) were married, 52(34.0%) were single and 14(9.2%) were divorced. And 115(75.2%) attended formal education varying from primary school to university level.

Table 1: Distribution of socio demographic characteristics by frequency and percentage Attat Hospital, 2019

Characteristics	**Frequency**	**Percentage (%)**
AGE		
15 -19	29	19.0
20 -24	44	28.8
25 -29	43	28.1
30 -34	22	14.4
35 -40	7	4.6
> 40	8	5.2
Marital status		
Single	52	34.0
Married	87	56.9
Divorced	14	9.2
Level of education		
no education	38	24.8
primary	38	24.8
secondary	37	24.2
college	19	12.4
university	21	13.7
Place of resident		
Rural	99	64.7
Urban	54	35.3
Occupation		
employed	25	16.3
farming	27	17.6
house wife	47	30.7
merchant	37	24.2
under family support	10	6.5
other(daily worker ...)	7	4.6
Total	153	100.0

5.2 Reproductive history

Fifty five (36%) reported that current pregnancy ended in abortion was wanted while the rest 98(64%) reported unwanted. 102 (66.7%) knew at least one contraceptive method. A history of use of contraceptives was 82(53.6%). Those who not used before around 71(46.4%).The rest 51(33.3%) were uninformed about contraceptives. Most women were used injectable 49(59.8%),oral contraceptive16(19.5%) Implant 12(14.6%), IUD 3(3.7%), other (like natural method) 2(2.4%).

Around (46.41%) clients of the user of PAC were found on the gestational age of 4-8 weeks and about 7.8% is less than one month.(fig..2)

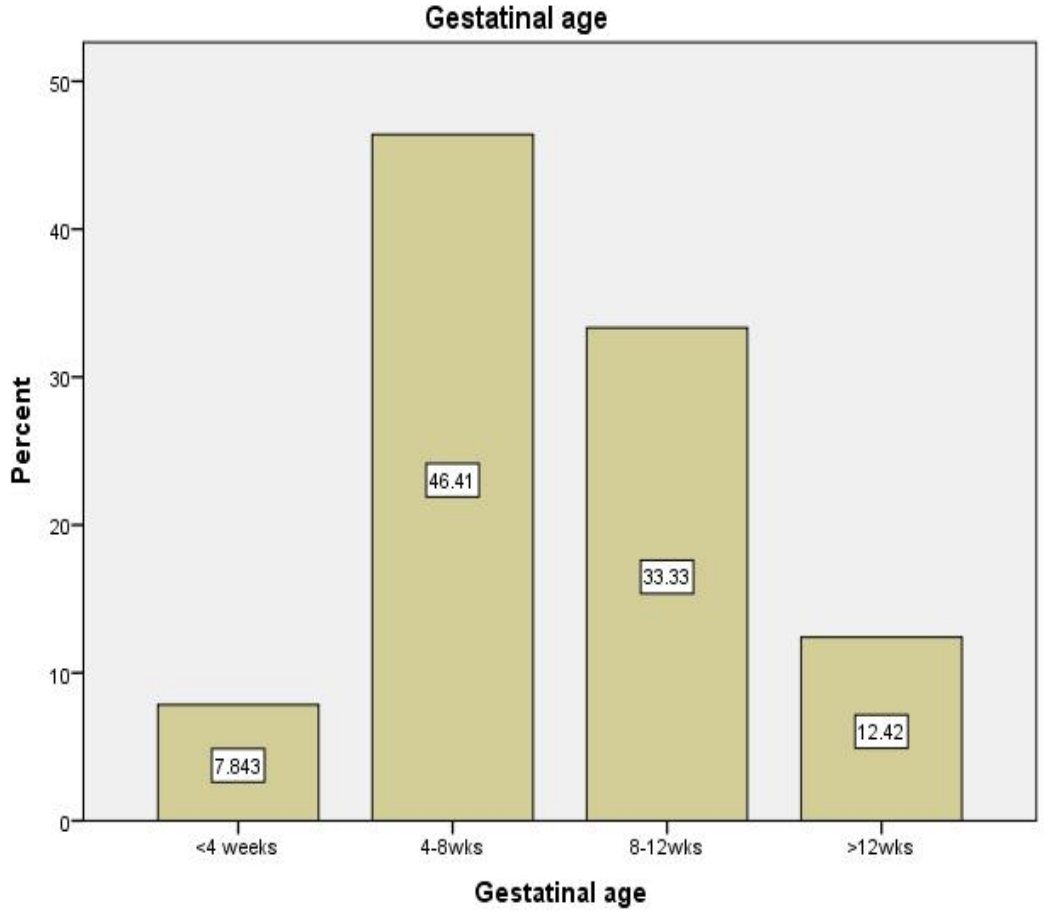

Figure 2: users of PAC gestational age by week with percentage history and LNMP in Attat hospital, from January to July 2019.

In this study around 56(36.6%)…users ere Para 1-3, and 54(35.29%) were null Para, 33(21.57%) Para 4-6 and10 (6.54%) were Para > 7 (fig…3)

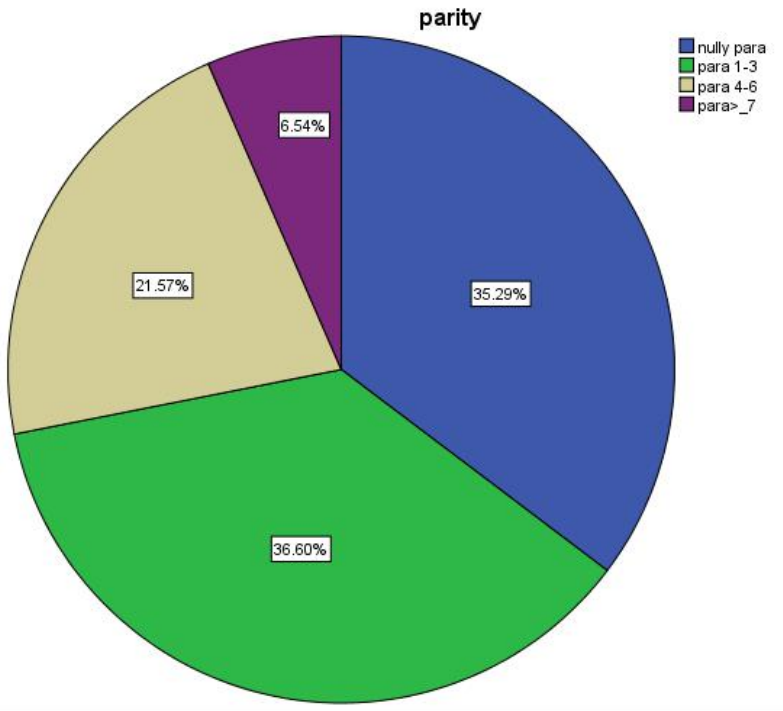

Figure 3: Parity of PAC users with distribution by percentage in Attat hospital from January to July ,2019.

5.3 Sharing of Information about One's Health Status

The study found that parents, significant others and partners influenced the seeking of care after complications. Most of the participants (39.3 percent) informed their partners about their health condition while others informed their close friends, relatives or parents. Participants who were not married were more likely to communicate their health problem to their nieboures, friends and parents than to their partners. On the other hand, those who were married shared information on their health condition with their partners rather than with their relatives and friends (Table 2).

Table 2: A Cross Tabulation of Whom the Users of PAC Services Shared Information about their Health Status by their Socioeconomic Characteristic

Characteristic		To whom the information was shared					Total %
		Partner %	Friend %	Relative %	Neighbor %	Provider %	Total
AGE							
15 – 19		4.2	79.2	8.3	8.3	0.0	100.0
20-24		45.9	8.1	0.0	40.5	5.4	100.0
25-29		33.3	37.5	20.8	8.3	0.0	100.0
30-34		70.6	23.5	5.9	0.0	0.0	100,0
35-40		28.6	0.0	0.0	71.4	0.0	100.0
>40		75.0	0.0	0.0	25.5	0.0	100.0
Marital status	Single	0.0	0.0	8.6	22.9	2.9	100.0
	Married	65.7	87.9	6.1	6.1	0.0	100.0
	Divorced	0.0	42.9	0.0	57.1	0.0	100.0
Level of education	No education	60.0	0.0	23.3	13.3	3.3	100.0
	Primary	38.1	47.6	0.0	14.3	0.0	100.0
	Secondary	28.6	14.3	2.9	54.3	0.0	100.0
	College	50.0	50.0	0.0	0.0	0.0	100.0
	University	13.3	80.0	0.0	0.0	6.7	100.0
place of resident	Rural	41.0	23.1	10.3	24.4	1.3	100.0
	Urban	35.9	43.6	0.0	17.9	2.6	100.0
Occupation							
employed		39.1	60.9	0.0	0.0	0.0	100.0
farming		75.0	10.0	10.0	0.0	5.0	100.0
housewife		43.8	0.0	3.1	50.0	3.1	100.0
merchant		27.6	20.7	17.2	34.5	0.0	100.0
under family support		0.0	100.0	0.0	0.0	0.0	100.0
other( )		0.0	100.0	0.0	0.0	0.0	100.0
Total N=117		39.3	29.9	6.8	22.2	1.7	100.0

This study also found that some of the users of PAC services made their own independent decision to seek care although they shared the information with someone. For example, those who were not married those with tertiary education and those who were employed were more likely to make their own independent decision to seek care (Table 2). This study showed that some users of PAC services admitted that they made their own decisions are around 61(39.9) to seek care even though their partners were made decided were around 68(44.4) . Partners offered support to their partners when they were contacted for the support of PAC following complication

Table 3: Users of PAC Services Decision to Seek Care, in Attat primary hospital from January to July ,2019

Made Decision to seek care	Frequency	Percent (%)
my self	61	39.9
partner/husband	68	44.4
parents	21	13.7
other specify	3	2.0
Total	153	100.0

Only 62 (40.5 percent) stated that they had ever heard about PAC services before. Those who knew about PAC services indicated that the main sources of information were healthcare providers were 45(72.6 percent,) mass media around 9(14.5%), from friends 5(8.1%), other 3(4.8%) About 106 (69.3 percent) of the users of PAC services indicated that they sought care elsewhere before visiting the study facilities. For those who sought care elsewhere, 3(2.8 percent) sought help from a pharmacy, 74, (69.8 percent) from a public health center, 29(27.4) percent from a private clinic. Those who visited a pharmacy reported that they bought some painkillers and decided to seek care from the studied facilities when they found that they would not recover after taking the drugs

The majority of the users of PAC services were from within the catchment area of Attat hospital. It took less than an hour for majority of them67 (43.8 percent).

About 60(39.2) around one hour the other 26(17%) greater than one hour to reach a facility for PAC services. The most common used mode of transport was public ambulance i.e. 97 (63.4

percent), motorcycle/Bajaj 36(23.5 percent) and public transport, 13 (8.5 percent), on foot, 7(4.6%)

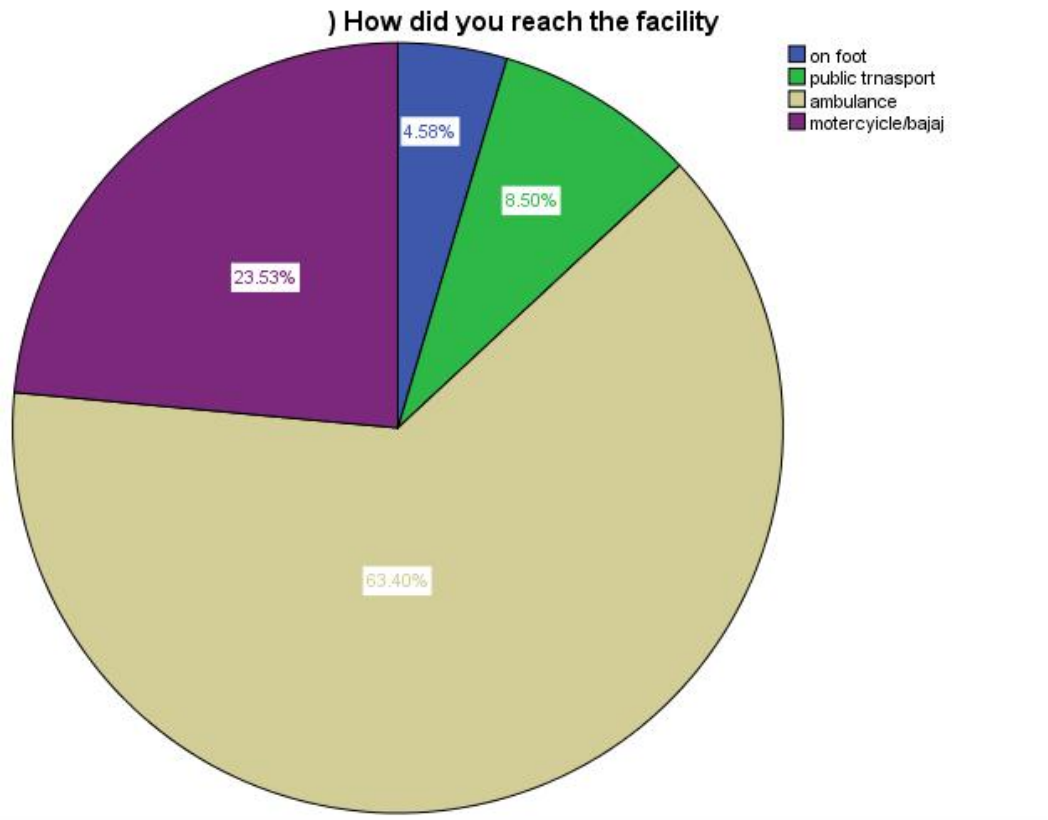

Figure 4: Mode of Transport Used by the Users of PAC Services to Reach to a Health Facility Attat hospital , from January to July 2019.

5.4 Providers' gender

The patients for PAC services were attended to by either a male provider 49 (32 percent), a female provider (17.6 percent) or both 77 (50.3 percent), depending on who was on shift when she was admitted. About 103 (67.3 percent) of the patients were comfortable being attended to by a male provider, 50 (32.7) percent were comfortable being attended to by a female, Patients who preferred a female provider had the following

I prefer a female provider because as a woman she will better understand my problems and so it will be easier for her to help me [User, 32 Years, Married).

If you are attended by a female provider she will feel it because she is a woman and so she will do it better [User, 24 Years, Not Married).

I prefer a female provider because she knows about women's issues and as a woman she will understand my problems better so it will be easier to help me [User, 29 Years

*, **Some of the patients who preferred a male provider indicated that**;*

When I compare them, male providers will not stigmatize you, they do not yell at you sometimes as female providers do [User, 19 Years, Not Married).

It is easy for a male provider to keep a secret and they do not use abusive language with clients [User, 25 Years, Married).

I like them because they are more competent than women and they are serious about their work [User, 30 Years, Married

This study has shown that provider's sex was not a concern to most of the users of PAC services.

5.5 Place of Uterine Evacuation, pain management and recovery room

The study facility varied in the areas where almost all 125(81.7) uterine evacuation was performed in operating theater, 27(17.6%) was performed in a ward, and 1(0.7%) in a special place covered by screens. The facility had no designated MVA room because of limited facility space. This ward served both the patients for PAC services and post-natal mothers. Therefore, this affected the privacy of the users of PAC to some extent. It was easy for the post-natal mothers to hear providers 'conversation and patients 'screams (if any) during the uterine procedure. Some of the users of PAC services who were treated in this facility felt that the post-natal mothers over heard the providers **'**conversation during counseling.

Only 21(13.7%) users of PAC service feel pain and 132(86.3%) were given pain medication and didn't feel pain during procedure. On the other hand there were 25(16.3%) users rest at the recovery room after the procedure, and more than 128(83.7%) were not arrested at recovery room from that rested at recovery room 22(88%) of users of PAC services rested the same room

from the adult so only 3(12%) clients separate from recovery room so 80% of this clients were not comfortable with that rest room

5.6 POST ABORTION CARE COUNSELLING PRIVACY AND CONFIDENTIALITY:-

In this study only half 77(50.3%) , provided on-site counseling for the users of PAC services other 76(49.7%)were not given PAC counseling . The counseling was provided either by doctors or nurses before or after the client had been treated for abortion complications. About the users received that given counseling 64(83.1%) of client were counseled in ward, only 10(13%) were in counseling room and 3(3.9%) were counseled from other site like outpatient department.

Users of PAC services who were in the age group 20-25 were more likely to receive PAC counseling compared to the users in the other age groups. On the other hand, those who were in the age group >35 were more likely to miss PAC counseling compared to others. Users of PAC services who had secondary and tertiary education were more likely to receive counseling compared to those who had primary education.

Table 4: Displays the percentage of the patients who received counseling per their socioeconomic and demographic characteristic

Characteristic		**Counseling**		Total
		Offered (%)	**Not offered %**	%
Age	15 - 19	44.8	55.2	100.0
	20 - 24	63.6	36.4	100.0
	25 - 29	44.2	55.8	100.0
	30 - 34	59.1	40.9	100.0
	35 - 40	28.6	71.4	100.0
	> 40	25.0	75.0	100.0
Marital status	Single	40.4	59.6	100.0
	Married	55.2	44.8	100.0
	Divorced	57.1	42.9	100.0
Religion	Christian	51.9	48.1	100.0
	Muslim	49.5	50.5	100.0
Occupation;-	employed	39.5	60.5	100.0
	farming	60.5	39.5	100.0
	house wife	67.6	32.4	100.0
	merchant	68.4	31.6	100.0
	under family support	4.8	95.2	100.0
	other(student...)			
level of education	no education	52.0	48.0	100.0
	primary	40.7	59.3	100.0
	secondary	63.8	36.2	100.0
	college	43.2	56.8	100.0
	university	60.0	40.0	100.0
	Total	77	76	153
	N = 153	50.3%	49.7%	100.0

5.7 Privacy during Counseling

The study found some variations regarding where counseling was provided in the study facilities. Facility had no special counseling room .47(61) percent of the clients who received counseling in the facility stated that the privacy of the counseling place was satisfactory. Counseling was provided in the OPD room or the ward (while a patient was lying on a bed) in the facility 30(39%) was unsatisfactory. Privacy especially during counseling is very important in the delivery of PAC services. Having a separate room for PAC counseling may help to ensure privacy but it may not be possible in most cases. Alternatively, the providers may use curtains and sit beside client's bed and speak softly. This is practical where a bed is occupied by one patient, and some of the providers in one of the study facilities applied it. The challenge encountered by the providers was the difficulty to provide counseling to a PAC services user when a bed was shared.

5.7 Post-Abortion Care Family Planning

About 130(85 percent) of the users of PAC services were not offered a family planning method. Only 23(15%) were offered a family planning method .from nonusers of post abortion family planning only 6(4.6%) are referred to another facility for family planning. The other 124(95.4%) not referred to another facility.

5.8 Patient provider interaction

The majority of the respondents 110(71.9%) said they were treated well with politeness and respect. Data from this study also showed that majority 125(81.7%) of the patients were side that greeted in a friendly and polite manner and in 120(78.4%) of the patient the service providers were supportively speak to them during the patient provider interaction and not used abuse language. Most of the service providers 69(86.3%) did not introduce themselves to patients by name. The rate of client interaction with the service providers more than half 118(77%) were satisfactory with their providers (fig…..5)

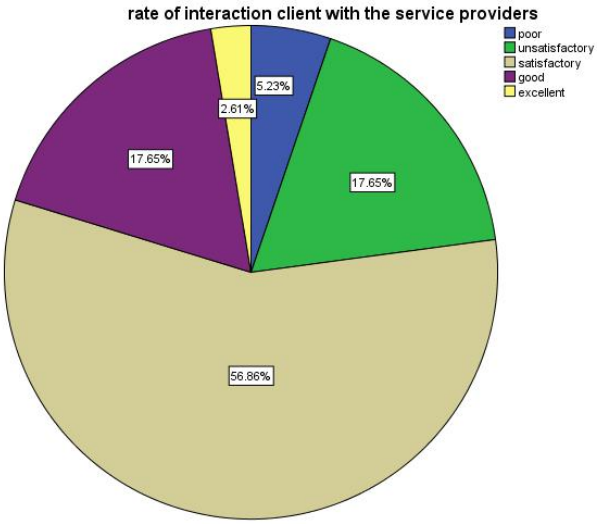

Figure 5: rate of client interaction with the service provider by their response in Attat hospital from January to July, 2019

5.9 Information provision

With regard to information provision; only 41(26.8%) of the post abortion cases received information on current illness and family planning counseling, and 112(73.2%) of the cases were not told about danger signs that may necessitate revisiting the facilities. Follow-up appointment was given only for 50(32.6%) of the post abortion women.

5.10 Access to service and satisfaction

Forty one (26.8%) of the patients responded that the waiting time between arrival and treatment was very long and 79(.51.6) were satisfactory to get service after arrival. . Overall, 118(77.1%) of the patients expressed that they were satisfied with the services received. Among those user 35(22.9%) patients who have difficulty in locating the service the majority mentioned presence of uncooperative staff as their main reason for their difficulty in getting the service.

Bivariate analysis in the binary logistic regression model showed that abuse language used providers towards women that used of post abortion care service was significantly associated with PAC used client satisfaction ; respondents who had not abused were satisfied post abortion services about 10 times when compared to who didn't satisfied (COR=10.77 [95%

CI=4.45, 26.05]). Women's who had short waiting time towards post abortion care were satisfied PAC service than who had long waiting time towards the service (COR=0.38 [95% CI=0.004, 0.389]). Women's who had room of rest after procedure had 5 times more satisfied than no rested at room after the procedure .clients who had keep privacy during counseling of PAC services had more satisfied than Not satisfied with their privacy during. Counseling (COR=0.202(95%CI=0.086, 0.472)

Table 5: Bivariate and multivariate analysis of factors associated with quality of post abortionCare utilization among reproductive age women in Attat catholic, primary hospital, Gurage zone, Ethiopia, 2019

Variables	**Satisfied PAC services**		**Unsatisfied PAC services**			
	N=118	**%**	**N=35**	**%**	**COR (95%CI)**	**AOR (95% CI)**
abuse language was used						
YES	13	11	15	43	1	1
No	105	89	20	57	10.77 (4.45,26.05)	5.237 (17.666, 2,002.672)
Waiting time						
Short	117	99.1	4	11.4	0.38 (0.004,0.389)	
Too. Long	1	0.9	31	88.6	1	
Room of rest after procedure						
Yes	118	100	0	0	4.89 (1.103,21.733)	15.164 (2.469, 93.147)
No	0	0	35	100	1	1
Privacy during counseling						
Yes	80	67.8	22	62.9	0.202 (0.086,0.472)	
No	38	32.2	13	37.1	1	

PAC: Post Abortion Care; **COR:** Crude Odds Ratio; **AOR:** Adjusted Odds Ratio;
CI: Confidence Interval

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Multivariate analysis (Adjusted for age, marital status educational status, sex of provider and abused .language) showed that statistically significant difference was observed on response to abused language and had rest room after the procedure. Those who had rest at rest room after the procedure were more satisfied (AOR = 15.164, CI = (2.469, 93.147)) than their counter part. Compared that post abortion clients who were abused with language , were less likely to be satisfied with the post abortion service delivered (AOR = 5.237, CI = (17.666, 2,002.672)).

Figure 6 : waiting time of client to get post abortion care services after coming at Attat hospital from January to July , 2019

5.11, Technical competence and post abortion care providers training

From the 15 health professionals who received the questionnaire, 2(13.3%) were health officers, 9(60%) were nurses and midwifery and 4(26.7%) were general practitioners who provide services during data collection period. The majority of the nurses, health officers and all general practitioners handled pelvic examination, history taking and operative procedures. Some nurses were involved in taking vital signs, counseling and assisting physicians. 5 (33.3%), 4(26.7%) and 6 (40%) had training on STDs counseling, HIV/AIDS counseling and MVA/and PAC family planning during their basic education respectively. Regarding training background 10(66.7%)

and 5(33.3%) providers have taken a refresher or post basic training on FP counseling and method provision and MVA respectively.

5.12 Inventory and equipment

Relevant equipment's, supplies and medications required to provide PAC in the studied health facility were assessed. The availability of equipment's, supplies and medications in the health facility to fulfill the required basic equipment by the MOH, WHO and international organizations such as IPAS were examined. I have selected list of equipment's recommended by WHO (such as water sink), supplies required by MOH (such as glove) and medications required by IPAS (such as from antiseptic). From the equipment, supplies and medications required, the facilities have most of the materials. Equipment and facility such as toilet near to PAC rooms, sinks and running water were present in the study facility Further more vital equipment like ambu bags, oral airways, suction apparatus, oral air ways and oxygen apparatus were present in most of the unit of service of this hospital but they were available in the major operating theaters of the hospitals that were not always near to where PAC provided. Family planning methods were not available in type and amount. All types of contraceptive were totally absent except for oral contraceptive and permanent contraceptives

CHAPTER SIX;- Discussion

The mean age of the users of PAC services was 27.2 years while the median age was 25. More than quarter (28.8) were aged 20-24years . In other words, close to half (47.7 percent) of women who utilized PAC services from the study facility were below 25 years. Age groups 15-19 and 20-24 represent adolescents and young women respectively This finding confirms the earlier studies in Tanzania that most of the users of PAC services are likely to be under 24 years(9). They also corroborate findings in Ethiopia Addis Ababa public governmental hospital, Nigeria and Zambia that users of PAC services are more likely to be under 25 years (7), respectively. Having a high proportion of younger women seeking PAC services may be associated with an improvement in their care-seeking behavior (10). This study found that more than half (56.8 percent) of the users of PAC services were married. Around (43.2) percent were not married. This finding is not similar to findings by studies in Ethiopia (9, 10,), This Studies shown that women who are married are more likely to seek PAC services than unmarried women this is similar to findings by study in tigry 42.9% (14, 19). From this finding, both married and unmarried women may seek PAC services in the case of the abortion complications

Around 115(75.2%) attended formal education varying from primary school to university level. Only 24.8 percent were not educated. Having formal education may be one of the facilitating factors for their seeking of PAC services from the study facility.

Formal education attainment among women may have a positive impact on utilization and quality of PAC services. A study in Pakistan found that education contributed to high acceptance of PAC services (13).

Most of the participants (39.3 percent) informed their partners about their health condition while others informed their close friends, relatives or parents A recent study in Indonesia indicates that almost all women who sought PAC services discussed their health status with their partners. Their partners even recommended the type of facility to seek care from (5). The study does not indicate whether the partners paid for the services. A similar finding is reported by studies in Ethiopia, tigriy and Addis Ababa (40%). and Nigeria whereby approval to seek PAC services was sought from the partner (11)

In this study Only 62 (40.5 percent) stated that they had ever heard and knows about PAC services before. A study in Ethiopia Addis Ababa public health facility found that women who knew about the components of PAC services were seven times more likely to utilize PAC services than women who did not have knowledge about PAC services (13). Similarly, a study in Pakistan found that women who knew about the availability of PAC services utilized the services. The study further noted that, women who did not know about PAC services sought care from local *Dias* (traditional birth attendants) (15). Poor information about the availability of PAC services may hinder women from receiving quality PAC services (15).With regard to information provision; only 41(26.8%) of the post abortion cases received information on current illness and family planning counseling, and 112(73.2%) of the cases were not told about danger signs that may necessitate revisiting the facilities. Follow-up appointment was given only for 50(32.6%) of the post abortion women

With regard to information pertaining to complications or danger signs were told to revisit the facility if the danger signs happens is relatively high as compared to a study done in government hospitals of Addis Ababa 21(5.3%) showing an improvement in terms of service provider awareness about the importance of providing this information from time to time but still needs immense attention [13]

In this study facility varied in the areas where almost all 125(81.7)uterine evacuation was performed in operating theater , 27(17.6%) was performed in a ward, and 1(0.7%)in a special place covered by screens so in this study uterine evacuation was performed at operating theater had good opportunity for the users of PAC services in other study from Addis Ababa public health facility and gurage zone three facilities most of uterine evacuation were performed in a ward, in a special place covered by screens (11)

In this study only 21(13.7%) users of PAC service feel pain and 132(86.3%) were given pain medication and didn't feel pain during procedure. Compared from study from gurage zone public health facility in 61(76.3%) of the cases there was evidence of pain and the pain was not adequately controlled throughout the procedure and only 17(21.3%) were given pain medication. So this hospital has good habits for pain medication (11)

This study showed that statistically significant difference was observed on response to abused language and had rest room after the procedure. Those who had rest at rest room after the procedure were more satisfied (AOR = 15.164, CI = (2.469, 93.147)) than their counter part. Compared that post abortion clients who were abused with language, were less likely to be satisfied with the post abortion service delivered (AOR = 5.237, CI = (17.666, 2,002.672)).

clients who had keep privacy during counseling of PAC services had more satisfied than Not satisfied with their privacy during counseling (COR=0.202(95%CI=0.086,0.472). Privacy is one of the key factors of quality PAC (6). Some participants from other districts of Dare Salaam sought PAC from the study facilities because of privacy

In this study Women's who had short waiting time towards post abortion care were satisfied PAC service than who had long waiting time towards the service (COR=0.38 [95% CI=0.004, 0.389]).to get service after arrival this is the same in A study in Ethiopia gurage zone governmental hospital indicated that long waiting time was one of the causes of dissatisfaction reported by the users of PAC services (11). The patients for PAC services were attended to by either a male provider 49 (32 percent), a female provider (17.6 percent) or both 77 (50.3 percent), depending on who was on shift when she was admitted. About 103 (67.3 percent) of the patients were comfortable being attended to by a male provider, 50 (32.7) percent were comfortable being attended to by a female; this study has shown that providers sex was not a concern to most of the users of PAC services. Studies elsewhere have the same documented that the provider's sex is not a major concern to users of PAC services that study in Addis Ababa public health facility (7).This study revealed that 23(15%) of the cases received contraceptive method after post abortion care. This is, however, discouraging very low as compared to a study conducted in Tigray (31%) and public health facilities in Ethiopia Addis Ababa (44.7%) of the PAC cases received family-planning services before leaving the facility [8,13]. Family planning program should be intensified to meet the needs of post abortion patients and developments in policy as well as program should intend to improve contraceptive use among post abortion clients through addressing the unmet need for post-abortion family planning services to prevent repeat unplanned pregnancies The overall client satisfaction level 118(77.1%) was slightly lower than a previous study in Ethiopia tigry gurage zone as well [8] where 79.6% of the patients expressed their satisfaction with the services they received and lower than a study in government hospitals

in Addis Ababa [6] in that 92.5% of the patients expressed that they were satisfied with the service received. These results imply that the service is doing a reasonably good job from the perspective of the clients in this and other studies. In this study as in previous study [6].This study has also shown that significant proportions of providers were trained on important aspects of PAC. Appropriate equipment and supplies needed for providing PAC including MVA equipment and pain medication were available this health facility. This was considerably better than a facility based assessment of quality of post-abortion care done in Ethiopia gurage zone government public hospital where only one-quarter of the health facilities had MVA equipment's and pain medication [11]. These achievements were mainly due to the joint effort by development partners in the health sector .on the other hand in this study Family planning methods were not available in type and amount. all types of contraceptive were totally absent except for oral contraceptive.it is different from other study like Tanzania dare slam and Addis Ababa ,and tigry, as well as gurage zone governmental hospital.(9,10,11,19)

6.1 Strength and weakness of the study

The strength of the study; the study has considered different assessment techniques such as patients and provider's perspective, inventory assessment and service observation. This study also has some weaknesses. During the service observation there could be a tendency by service provider to be at their best performance due to the presence of an observer. And the study has only focused on private health facility and doesn't give picture of PAC practice in public health facilities. All information provided about post abortion care services were from respondents reports which may have resulted in recall bias, respondents might not remember elements of PAC that they received. This study was cross-sectional and could not establish the process and circumstances leading to utilization and quality of PAC, we recommend more studies be conducted to answer these questions

CHAPTER SEVEN: CONCLUSION

The interaction of patients and service providers was satisfactory. However, from a clinical service delivery standpoint, important medical information on danger signs, follow-up needs of post abortion family planning and care associated keep privacy during counseling were neglected by most of the health professionals. Most of the clients were satisfied with the service provision. Long waiting time was associated with less level of client satisfaction and not abused with language and had rest room after the procedure of PAC service were more satisfied than others. Almost all except family planning services are available basic and appropriate medical equipment and supplies required for providing post abortion services. A majority of the service providers have taken training that is not up to date and focus on general management of PAC clients.

7.1 Recommendations

The study found that most of the users of PAC services missed counseling and family planning services. Most of the users who missed counseling services were those who utilized PAC services in the facility where family planning services were being offered at a separate section from the treatment place and those who sought care from the facility where counseling and family planning services were not offered at the same time as the treatment. This study recommends that family planning and counseling services should be offered in the same place/section to avoid clients moving from one location to another therefore missing some components of care. The study also found that lack of privacy during the delivery of PAC services and during counseling language was a concern to some of the users. Therefore, concerted efforts should be made to ensure that privacy is maintained and language abused and rest room after the procedure considerable for the users of PAC services to satisfy throughout the care to enhance utilization and quality of PAC services. This study recommends for more research at community level which can recruit a considerable number of the non-users of PAC services. Such studies will provide more insights on factors that hinder utilization and quality status of PAC services

CHAPTER EIGHT Reference

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ANNEX- Questionnaire

I am Tesfaye berie , IESO student at Jimma university . I am doing a research on Factors Associated with Utilization and quality STATUS Post abortion Care (PAC) Services in Attat PRIMERY hospital : I would like to discuss with you some issues regarding this topic. You are being chosen to take part in this research because you have used these services, therefore your experience as a user may facilitate the understanding of the topic. Your participation in this study is voluntary. You are free to take part or not. You are also free not to respond to some questions and also to quit from the interview at any time you wish. Your choice not to participate in this study will not have any effect on your treatment at this health facility. That means nothing will change regarding services you receive at this health facility. During the interview, you will be asked to share some confidential and personal information which you may not be comfortable to talk about. You are free not to share such information and you do not have to explain to the investigator the reasons for not sharing. During the interview, I will sit with you in a room in this health facility where no one else except the researcher will be present. The entire interview will be tape recorded but your name will not be identified. If you do not want the interview to be tape recorded, please feel free to do so. The information recorded is confidential and no one else except the researcher will have access to the recorded information. If you have any question or an area, you need more clarification please feel free to ask. The information you are going to provide will help us to understand factors associated with utilizationand quality of post abortion care services in Attat primery hospital . It will also be of help to the government, policy makers as well as organizations dealing with provision of post-abortion care services in Guragea zone health district

For more information, you may contact the following
TESFAYE BERIE
Phone no,0947304258 email tesfeshe2007@gmail.com

Check List

Appendix II: Research Instruments

INTERVIEW GUIDE FOR THE USERS OF PAC SERVICES

This questionnaire was administered to the users of PAC services when they were about to leave the health facility. The aim of the interview was to solicit information on the factors that facilitated their seeking of care and their perceptions on the quality of services they have received. Questions on quality of PAC were based on the international recommendations of quality PAC services**.**

FACILITY AND CLIENT'S BACKGROUND INFORMATION

Facility's Code*: _____Date of Interview: _____

Ward _____

Type of Facility: 1. Government __❒ 2. Private__❒

Level of the Facility: _____ (e.g., Health Center, Hospital)

Interviewer's Names _____

(Codes were assigned to each participating facility instead of using their actual names for confidentiality purposes).*

A: CLIENTS' SOCIOECONOMIC AND DEMOGRAPHIC INFORMATTION

Age of the client (in years) _____: (1) 15-19yrs (2) 20-`24yrs (3) 25-29yrs (4)30-34yrs (5) 35-39yrs (6) 40-44yrs (7) 45&olde

Marital status: Single _1. Married__ 2,Separated/Divorced _

Client's religion 1. Christian_ 2. Muslim_ 3. other_

Client's highest level of education: 1. No education _ 2. Primary_ 3. Secondary_4. College_ 5. University_

Current place of residence: rural _____town_____

Occupation: 1. Employed_ 2. Farming_ 3. Housewife _4. Merchant 5. Under family support_ 6. Other (Specify) _____

B: CONTRACEPTIVE USE HISTORY

(i) Have you ever used a contraceptive method (s)? 1. Yes_ 2. No_

(ii) Which method have ever used *(put a tick).*

(a) Male condom ()

(b) Female condoms ()

(c) Pills ()

(d) Norplant ()

(e) Cervical diaphragm ()

(f) Spermicides ()

(g) Injectable ()

(h) Loop ()

(i) Natural methods ()

(iii) Were you using a contraceptive method in the time of conception?

1. Yes_ 2. No_ (iv) If **NO**, why? _____

D: FACTORS THAT BROUGHT THE CLIENT TO A HEALTH FACILITY .

Gestational age: (1) <4wks…. (2) 4-8wks …… (3) 8-12wks…… (4) >12wks……

.1Parity; (1) null Para…… (2) Para 1-3…… (3)Para 4-6…….(4)Para≥7……

(i) When did your problem start? _____

*(*for clients who stayed more than one-day probe why they didn't seek care immediately*)*

(ii) Did you communicate your health problem to someone? 1. Yes_ 2. No_

(iii) If YES pleas indicate whom you communicated your health problem with 1. Partner_ 2. Friend_ 3. Relative_ 4. Parent_ 5. Neighbors_

6. Provider_ Other (specify) _____

(iv) Who made the decision for you to seek care? 1. Myself_ 2. Partner/husband_

3. Parents_ 4. Other (specify) _____

(v) Did you know about PAC services before? 1. Yes_ 2. No _

(vi) Where did you get information about PAC?

1. Healthcare provider_ 2. Friend _ 3. Mass media_ 4. Parents_

5. Posters 6. Other (specify) _____

(vii) Did you visit any other facility for the same services before you came here?

1. Yes_ 2. No_

(viii) If **YES,** what type of facility did you visit? 1. Pharmacy_

2. Public health center_ 3. Private health center _ 4. Private dispensary _ 5. Public dispensary . Private Hospital_ 6. Public hospital _ 7. Traditional healer 8. Self-medication _ 9. Other (specify) _____

(ix) If you visited that facility, why did you come to this facility? _____

(x) How did you reach the facility? 1. On foot_ 2. Public bus_ 3. Ambulance

3. Hired car (taxi) 4. Private Transport_ 5. Motorcycle/Bajaj_

Other (specify) _____

(xi) Who catered for the transport costs? 1. Myself_

2. Partner/husband _ 3. Relatives_ 4. Parents_ 5. Friend_

6. Other (specify) _____

(xii) How much time did you use to reach this facility?

1. Less than an hour_2. One hour_ 3. More than one hour_

4. Other (specify) _____

E: PROVIDERS' GENDER

(i) What is the gender of the provider (s) attended you today?

1. Male_ 2. Female_ 3. Both _

(ii) Did you feel comfortable attended by the provider you have stated above?

1. Yes_ 2. No _

(iii) Between male and female provider whom are you more comfortable to be attended to?

1. Male_ 2. Female_

(iv) Why do you prefer the provider's gender you have mentioned above? _____

F: PLACE OF UTERINE EVACUATIN, PAIN MANAGEMEN AND RECOVERY ROOM

(i) Where were you treated? 1. Ward_ 2. Operating theatre_ 3. Other _____

(ii) Was there someone to assist you to the procedure room? 1. Yes_ 2. No _

(v) Did you feel pain during the procedure? 1. Yes _ 2. No_

(vi) Were you given any medication for pain control? 1. Yes _ 2. No_

(vii) Was there a room where you rested after the procedure? 1. Yes _ 2. No_

(viii) Were you assisted to the recovery room after the procedure? 1. Yes _ 2. No_

(ix) Were you in the same recovery room with the adult? 1. Yes _ 2. No_

(x) Did you feel comfortable there? 1. Yes _ 2. No_

(xi) Do you think young people should be mixed with adults for this type of care?

1. Yes _ 2. No_

F: PLACE OF UTERINE EVACUATIN, PAIN MANAGEMEN AND RECOVERY ROOM

(i) Where were you treated? 1. Ward_ 2. Operating theatre_ 3. Other _____

(ii) Was there someone to assist you to the procedure room? 1. Yes_ 2. No _

(v) Did you feel pain during the procedure? 1. Yes _ 2. No_

(vi) Were you given any medication for pain control? 1. Yes _ 2. No_

(vii) Was there a room where you rested after the procedure? 1. Yes _ 2. No_

(viii) Were you assisted to the recovery room after the procedure? 1. Yes _ 2. No_

G: POS-TABORTION CARE COUNSELLING PRIVACY AND CONFIDENTIALITY

(i) Were you given counseling in this health facility? 1. Yes _ 2. No_

(ii) If NO, have you been referred to another health facility? 1. Yes _ 2. No_

(iii) If YES, were you given any information/document showing that your case is referral?

1. Yes _ 2. No_

*(*Continue if the client was given counselling at the facility*)*

(iv) Where was the counselling done? 1. Counselling room 2. Ward 3. Other (Specify) _____

(v) How many people were in the counselling room? _____

(vi) Were there any interruptions during counseling session? 1. Yes 2. No_

(vii) Do you think your issues about care were overheard during the discussion? 1. Yes _ 2. No

(viii) Do you think the privacy of the room was satisfactory? 1. Yes _ 2. No_

(ix) If NO, please explain _____

(x) Were you reassured that the information and treatment records will be kept confidential? 1. Yes _ 2. No_

H: POSTABORTION CARE FAMILY PLANNING

(i) Were you given a contraceptive method? 1. Yes _ 2. No_

(ii) If NO, have you been referred to another health facility? 1. Yes _ 2. No_

(iii) If YES, were you given any information/document showing that your case is referral? 1. Yes _ 2. No_ (*Continue if the client was given family planning at the facility)*

Was the contraceptive method given the one you d

I: INTERACTION WITH THE PROVIDER

(i) Do you think the healthcare providers treated you well? 1. Yes _ 2. No_

(ii) Was the provider (s) concerned about the cause of your problem?

1. Yes _ 2. No_

(iii) Did you notice anywhere where abusive language was used? 1. Yes _ 2. No_

(iv) Were you blamed by anyone for your condition? 1. Yes _ 2. No_

(v) How do you rate the interaction with the service provider (s)?

1. Poor_ 2. Unsatisfactory_3. Satisfactory_4. Good_5. Excellent__

J: WAITING TIME

(i) How long did you have to wait today before you saw a doctor, a counsellor or nurse?

A. Nurse____ minutes/Hours

B. A doctor? ____minutes/Hours

C. A counsellor? _____minutes/Hours

(ii) In which section/s do you think you spent long time? _____

1. What is your opinion on the time you waited before receiving care?

2. Short __ 2. Too Long __ 3. Satisfactory__

L: INFORMATION FOR FOLLOW UP

(i) Did the provider tell you re you told when to return for routine follow-up care?

1. Yes _ 2. No_

(ii) Did the provider tell you why you need to return for follow up? 1. Yes _ 2. No_

(iii) Were you told where to return for follow-up care? 1. Yes _ 2. No_

Did the provider tell you the importance of seeking medical attention if problems arise?

1. A: POSTABORTION CARE PROVIDER'S TRAINING

(i) For how long have you been working in this health facility? _____

(ii) Are you trained in PAC? 1. Yes_ 2. No_

(iii) What kind of PAC training do you have?

1.College/University as a part of curriculum ____

2. In service training____ 3. Short course __

4.Reproductive health training__4. Other (specify)_____

(iv) When was your last training? On PAC? _____

(v) Do you have regular in service training? 1. Yes_ 2. No_

(vi) How often do you have in service training? _____

B: EQUIPMENT SUPPLY AND MEDICATION

(i) What are essential medicine and equipment needed for PAC services? _____

(ii) What method/s do you use to perform uterine evacuation? _____

(iii) Are essential equipment and medicine available all the time?

1. Yes_ 2. No_

(iv) If **No,** what does the facility do in case of the short supply? _____

(v) Are essential equipment and medication adequate compared to post-abortion cases you handle per day? 1. Yes_ 2. No_

(vi) Is running water available all the time. 1. Yes_ 2. No_

(vii) Is electricity available all the time? 1. Yes_ 2. No_

(viii) What are the options does the facility during power cut?

(ix) What are other challenges you encounter in providing PAC services in this facility?

: PROVIDER'S ATTITUDE TOWARDS ABORTION AND PAC CLIENTS

(i) How do you perceive/think of a woman who have had an induced abortion?

(ii) How do you perceive/think of a woman who have had a spontaneous abortion?

(iii) Do you think women with unsafe abortion complications should be denied services? 1. Yes_ 2. No_

(iv) Please give reasons for your response_____

(v) Do Women who have undergone unsafe abortion deserve equal attention like any other patients? 1. Yes_ 2. No_

(vi) Please give reasons for your answer _____

(vii) How do you perceive/think of PAC services?

(viii) Do you feel comfortable to provide services? 1. Yes_ 2. No_

((x) Do you think unmarried women may have additional challenges in accessing PAC compared to married women? Yes_ 2. No_

(xi) Please provide reasons for your answer _____

DIRECT OBSERVATION CHEKLIST

Items to be observed	**YES**	**NO**	**N/A**
Facility easy to be identified from the reception			
Treatment room clean			
Counselling services offered			
Privacy maintained			
Family planning available			
The facility had a wide range of family planning methods			
The facility has running water			
The facility had a special room for counselling			
The facility has electricity			
Room/space available for post procedure recovery			
Clients sharing bed			
Provider client interactions			

DECLARATION

ASSURANCE OF PRINCIPAL INVESTIGATOR

The under signed agrees to accept responsibility for the scientific ethical and technical conduct of the thesis result and provision of required progress reports as per terms and conditions of the college of Public Health & Medical Sciences in effect at the time of grant is forwarded as the result of this application.

Name of the student: Tesfaye berie

Date:_____ Signature:_____

APPROVAL OF THE ADVISOR

Name of the Advisor: Dr. Demisew Amenu (Consultant Obstetrician/Gynecologist, Associate Professor)

Date:_____ Signature:_____